

School District LETTERHEAD To Go Here

Date: _____

Dear: _____

[name of student's health care provider]

I am writing about your patient, _____ . Date of birth _____.

The following information is being provided for your information and records.

- Missed _____ days in _____ period of time, possibly due to asthma.
- Is not complying with asthma medication at school or the treatment plan you have provided.
- Is not fully participating in P.E.(or participating at all) because of symptoms related to asthma.
- Visits school health office frequently because of symptoms related to asthma.
- Has required emergency management of asthma (eg: 911, ER referral).
- Our history and observations reveal that this student's asthma severity may have changed.

The family was asked to schedule an appointment with you.

- A signed parent consent form to exchange information with the school is attached
- An unsigned parent consent form to exchange information with the school is attached; please ask parent to sign this at the visit.

Please help with the following, either before or after the patient's next appointment:

- Please consider prescribing a rescue bronchodilator medicine (e.g. albuterol) to be available at school. Based on my perception of this student's ability to use this properly (not to forget, over-use, or under-use), I recommend that the medication be: ____ (a) kept in HEALTH OFFICE; or ____ (b) kept on PERSON
- Please send me an "Asthma Action Plan" (attached form) so we can assist with your management plan.
- Student has no peak flow meter. Please consider prescribing one so that I may better assist with his/her management at school.
- Please consider prescribing a spacer. This student's technique with an MDI without spacer was observed and is not adequate.
- Please reassess this child and his/her current medical regimen. (See comments above about his lack of asthma control noted at school.)
- Other _____

Do not hesitate to reach me if there are any questions or concerns. Thank you!

Sincerely,

School nurse signature

School nurse printed name

School: _____ Ph: (____) _____ Fax: (____) _____ Best days/time: _____